Department of Behavioral and Developmental Services

_____
Consumer's Name

Consent for Purposes of Treatment, Payment and Healthcare Operations

This consent form may be used ONLY for Department of Behavioral and Developmental Services (BDS)

- **adult mental health intensive case management services;**
- **adult mental retardation case management services;**
- **adult mental retardation crisis services;**
- **admission to Aroostook Residential Center, Elizabeth Levinson Center, Freeport Towne Square.**

Any other use makes this consent invalid.

I consent to the use or disclosure of my protected health information by _____ for the purpose of providing services to me, obtaining payment for bills for services I receive, or to conduct health care operations.

My protected health information means health information, including information that identifies me, that I have provided. It also means information that service providers have created about me and information that has been shared about me. This protected health information includes my past, present or future health or condition or services. It includes information that could be used to identify me even if my name is not used.

I have been provided a copy of the *Notice of Privacy Practices.* I understand that I have a right to review the notice before signing this form. I understand that BDS can change the notice and their privacy practices. I can get a copy of the changed notice by contacting _____. I understand that the notice is posted in _____ and on the web page for BDS http://www.state.me.us/bds/HIPAA/PrivacyNotice/ConsentTreatment.html
I understand that I have the right to ask for restrictions on how my protected health information is used. I understand that BDS does not have to agree with the restrictions I ask for.

_____
My signature **Date**

_____
Signature/Relationship of Personal Representative **Date**

Department of Behavioral and Developmental Services

Witness **Date**